Clark County
Regional Support Network

Inpatient Data Form

ADMISSION INFORMATION

NAME (Last, First, MI): _____

ADDRESS: _____

CITY: _____ ST.:_____ ZIP: _____ COUNTY: _____

D.O.B: _____/_____/_____ PHONE: (_____)_____

PIC NUMBER:_____
(Not required for Non-Medicaid eligible persons involuntarily admitted)

CLIENT ID#: *(If one exists)*_____ S.S. #: _____-_____-_____

ETHNICITY: _____ HISPANIC: ❑ YES ❑ NO LANGUAGE: _____

GENDER: ❑ MALE ❑ FEMALE

HOSPITAL:_____

INSURER: _____ INCOME: _____

COURT NUMBER: _____ RETRO ?: _____

ADMISSION DATE: _____/_____/_____ DIAGNOSIS (ICD-9-CM CODE): _____

CURRENT LEGAL STATUS:
- ❑ Voluntary admission
- ❑ 72 hour emergency detention for:
  - ❑ Imminent risk of harm to self
  - ❑ Imminent risk of harm to others
  - ❑ Gravely disabled
  - ❑ Revocation Petition for consumer's LRA

DISCHARGE INFORMATION

NAME (Last, First, MI): _____

DISCHARGE DATE: _____/_____/_____

DISCHARGE DIAGNOSIS (ICD-9-CM Code): Axis I:_____ Axis II:_____

ZIP CODE: _____

DATE OF FOLLOW-UP APPOINTMENT: _____/_____/_____

DISCHARGE PLAN: _____

AGENCY NOTIFIED OF D/C: _____ DATE OF NOTIFICATION: _____/_____/_____